OMH Statewide Town Hall – November 2017

A Vision for the NYS Public Mental Health System

November 8, 2017

Ann Sullivan, M.D., OMH Commissioner

Note: The content in this presentation is draft, and many figures may become outdated after publication. Please contact the OMH Planning Office before citing the data herein.

Before We Get Started

- **How to send questions:**
  - Online participants can type questions or comments into the “Chat Box” at any point during the presentation.
  - In-person participants can present questions, comments, or formal testimony on site.
  - Also accept and encourage submission of additional comments through December 15th to transformation@omh.ny.gov

- **How to view full screen:**
  - Go to the top right hand corner of the PowerPoint
  - Click the icon showing two arrows

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Presentation Outline

- ❑ **Opening Remarks**
  - Ann Sullivan, M.D., OMH Commissioner
- ❑ **Panelist Presentations**
  - Robert Myers, Ph.D., Senior Deputy Commissioner & Division Director
  - Donna Bradbury, MA, LMHC, Associate Commissioner of Integrated Community Services for Children & Families
  - Christopher Tavella, Ph.D., Executive Deputy Commissioner
- ❑ **Public Remarks and Testimony**
- ❑ **Moderator**
  - Jeremy Darman, Director of Planning

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Vision for the Future Mental Healthcare System

Ann Sullivan, M.D.,
Commissioner

Office of Mental Health

OMH Mission

The Mission of the New York State Office of Mental Health is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances.

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OMH Vision

1. **Recovery Oriented System Design:** Integrated, accessible, and sustainable systems of high quality, person-centered, resiliency-and recovery-focused health and behavioral health supports and services.
2. **Promotion and Prevention:** Mental and physical wellbeing, and community and social environments that reduce the incidence of disorders, eliminate stigma, and foster community inclusion.
3. **Engagement of Most At-Risk:** A strong continuum of institutional and community systems to support at-risk individuals, and promote individual and public safety.
4. **Total Health:** Population health, without disparities.

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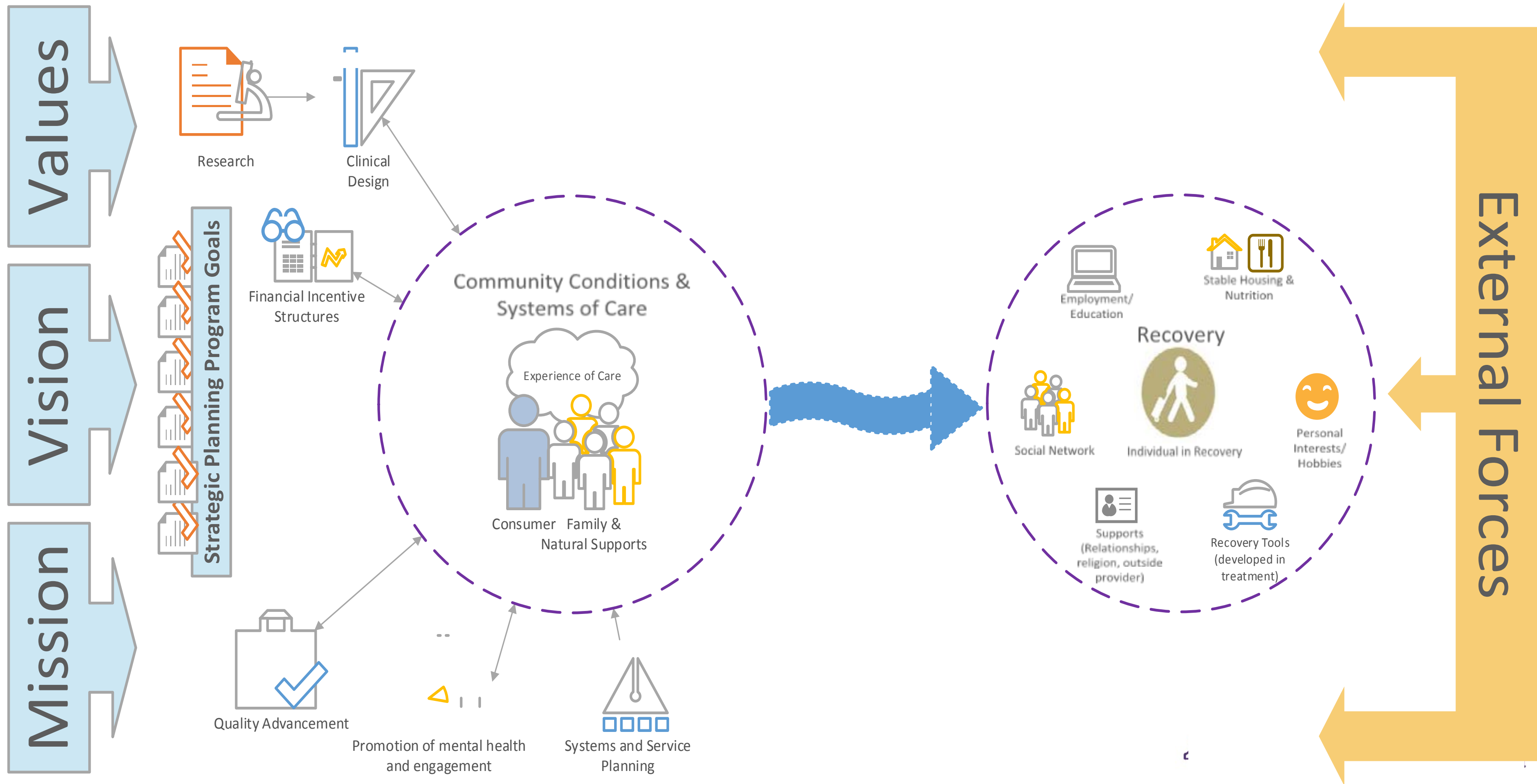
Values
Vision
Mission
Strategic Planning Program Goals
Research
Clinical Design
Financial Incentive Structures
Community Conditions & Systems of Care
Experience of Care
Consumer
Family & Natural Supports
Quality Advancement
Promotion of mental health and engagement
Systems and Service Planning
Recovery
Employment/ Education
Stable Housing & Nutrition
Social Network
Individual in Recovery
Personal Interests/ Hobbies
Supports (Relationships, religion, outside provider)
Recovery Tools (developed in treatment)
External Forces

Putting Vision in Action: Major efforts in next 3-5 years to transform the MH system

- Recovery-oriented program design and financing: Managed care/HARP, HCBS services, care management, value-based payment
- Paving pathways from State inpatient and residential to independent community living, reducing avoidable hospital use
- Supporting childhood development and early to improve mental wellness, reduce disorders
- System and regulatory redesign to strengthen access, increase efficiency, and quality of care
- Promoting population health, engaging the public

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Year in Review

Year in Review – Progress and Challenges

1. Advancing recovery through service transformation:

- Approximately 100,000 HARP-eligible are enrolled
- HARP Health Home enrollees with HCBS assessment from 13.5% to 43% in past year
- Approximately 90% of HCBS assessed = HCBS eligible
- More work underway increase HCBS assessments, and provide alternative path to HCBS for those without Health Home
- Health Home + expansion to additional groups (PC & prison discharges). Pursuing future expansion for ACT step-down, disengaged from outpatient care
- VBP provider readiness applications issued (awards in November/December)
- Children's Health Home implemented December 2016

State Operated-Specific Recovery Indicators:

- 775 long stay individuals successfully discharged to the community in last SFY
- Adult competitive employment reached over 18% (annual rate)
- *13% increase in rate of competitive employment from 2014 and 2016*
- 30-day continuity of care up to 96%
- 30-day readmission down to 13%

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Year in Review – Progress & Challenges

2. Service expansion:

- ESSHI Units/beds for individuals with SMI: 35% of first 1,200 units
- Continue investing in housing pipeline and rate increases for stronger residential system
- $110M reinvestment committed to new community services; >30,000 new served
- 20 new ACT teams statewide
- Expanding services for forensic individuals, those who are at risk of being lost to care:
    - Specialized forensic transition-to-community units
    - Forensic housing and ACT allocations
    - Sustained engagement and supports for individuals disconnected from care

3. Service system and regulatory redesign

- Regulatory expansion for telepsychiatry
- Intensive Outpatient Program (IOP) guidance for clinics, adoption at several sites
- 71 approved Integrated Outpatient Services (IOS) clinic sites, most with MH component
- 13 CCBHCs began operating on July 1st across all OMH regions

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Year in Review – Progress & Challenges

4. Prevention and early intervention

- Healthy Steps for Young Children kicked off
- Project TEACH: Expanded child psychiatry consultation & telepsych and initiated new statewide coordination center
- Awarded Systems of Care (SOC) grant and continued dissemination of model
- OnTrackNY: Now 22 sites statewide; over 700 served in 2017 and 900 since program inception
- $3.5M five-year federal ‘Zero Suicide’ grant; NYS is only state government awardee
- Already over 60 OMH licensed programs adopting Zero Suicide model, exceeding initial targets for SFY 2018

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Supporting Recovery, Creating Value:

- Value-Based Payment
- Home and Community Based Services
- Defining Metrics

Robert Myers, Ph.D.
Senior Deputy Commissioner & Division Director

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Recovery Is The Goal: Independence, Community Integration, Well-being (not just reduction of symptoms)

- Some areas of focus/measures:
  - Residential stability
  - Employment
  - Life satisfaction, social & family engagement
  - Continuity and engagement in care
  - Reduction in crises and need for emergency care

- Defining and incentivizing recovery outcomes is critical, and a work in progress toward Value-based Payment

VBP for BH Care: Pay for Outcomes

- DSRIP and the State Innovations Model (SIM) are driving NYS providers to a value-based payment environment and integrated care will be measured and a key part of outcomes and payment

- Outcome Measures used to determine payments for value based arrangements in the HARP benefit will include: behavioral health outcomes such as engagement after psych hospitalization and physical health outcomes such as hypertension and diabetes control for people with schizophrenia

- Value based payments in the mainstream plan will include measures for depression in primary care such as screening and treatment outcomes; depression is one of the chronic illnesses to be managed and followed for outcomes in the mainstream plans

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Value Based Payment Transition Funds

- Value-based payment (VBP) clock has started, need to ramp-up readiness efforts
- Approximately $60M will be available over 3 years ($20M/year) through Managed Care Organizations (MCOs)
- Supporting qualified groups of community based behavioral health providers that form Behavioral Health Care Collaboratives (BHCC)

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Value Based Payment Transition Funds

- These partnerships will be organized around improving health outcomes, managing costs, and participating in Value Based Purchasing arrangements
- Anticipated awards in November/December

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Adult Behavioral Health Home and Community Based Services (Adult HCBS)

- Major opportunity to expand recovery supports across State
- Working to address uptake across HARP, Health Home, and HCBS assessment workflow

Supporting Community Integration for State Psychiatric Centers

- Residential redesign
- Mobile Integration Teams (MIT)
- Skilled Nursing Facilities (SNF) initiative
- LEAN projects
- Competitive employment

Christopher Tavella, Ph.D.,
Executive Deputy Commissioner

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Mobile Integration Teams (MIT)

- Eighteen facilities have Mobile Integration Teams. These teams focus on supporting discharge plans for long stay individuals, as well as working with individuals to maintain their community tenure.

- As of October 2017:
  - **5,306** individuals have been served
  - These 5,306 individuals have had **65,880** service visits with a member of the MIT
  - **101,809** services have been provided during these visits. (multiple services can be provided in the same visit)

- The top 5 service categories are:
  - Outreach/Engagement
  - Therapeutic Support
  - Skill Building
  - Community Linkage
  - Health Teaching

Team Name	Operating Facility
North Country	St. Lawrence PC
Southern Tier	Elmira PC, Greater Binghamton Health Center
Long Island Children's	Sagamore CPC
Rochester	Rochester PC
Western NY Children's	Western NY CPC
Long Island Adult	Pilgrim PC
Manhattan	Manhattan PC
New York City Children's	NYC Children's Center
Rockland	Rockland PC
Kingsboro	Kingsboro PC
Creedmoor	Creedmoor PC
Capital District	Capital District PC
Buffalo	Buffalo PC
Mohawk Valley	Mohawk Valley PC
Hutchings	Hutchings PC
South Beach	
Bronx	

Skilled Nursing Facilities (SNF)

- SNF discharge program funded by 2016-17 reinvestment
- Currently 52 SNFs statewide receiving enhanced supports for 111 individuals
- OMH collaborating with University of Rochester to support Project ECHO for SNFs, building competency for staff working with individuals with SMI

Using LEAN to Support Active Treatment

- **Active Treatment, LEAN Project**: OMH is partnering with NYS LEAN and Toyota in conducting lean activity aimed at improving patient flow, beginning in eight State Operated PCs
- Goal to discharge 90% of adult admissions within 180 days, 80% of child admissions within 90 days
- Currently participating hospitals:

New York City Children's Center (NYCCC)	Rockland
Pilgrim	Mid-Hudson
South Beach	Greater Binghamton
Creedmoor	Hutchings

Competitive Employment

- Employment rate for outpatient clinic enrollees continues to increase, but still low.
  - Adult competitive employment for state clinic enrollees reached over 18% for 2016.
  - 13% increase in rate of competitive employment from 2014 and 2016
- Working for greater improvement
  - Employment rate for those receiving Individual Placement Support (IPS*) at state clinics: 43.5%, demonstrating the great potential for recovery and social inclusion

(*IPS implementation support provided by the NYSPI Center for Practice Innovations, partnership of NYS Psychiatric Institute and Columbia University)

Children’s Transitions

- Project TEACH coordination center and expanded service contracts
- Healthy Steps milestones
- Children’s Medicaid Managed Care and Health Homes: Total transformation of the children’s delivery and payment system.
- Systems of Care

Donna Bradbury, MA, LMHC
Associate Commissioner of Integrated Community Service for Children & Families

The right services, at the right time, in the right amount

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Project TEACH

❑ Mission

- To strengthen and support the ability of New York's pediatric primary care providers (PCPs) to deliver care to children and families who experience mild-to-moderate mental health concerns.

❑ Vision

- A New York State where children and families receive **skillful, prompt and compassionate** care for mental health conditions

❑ The Way it Works

- Project TEACH provides consultation, education, training, and referrals and linkages to other key services for pediatricians, family physicians, psychiatrists, nurse practitioners, and other prescribers

- The Statewide Coordination Center (SCC) was created to increase awareness and buy-in from PCPs, families, stakeholders, and is charged with the promotion of Project TEACH throughout the State. SCC is currently engaging stakeholders

For more information on Project TEACH http://projectteachny.org/

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Project TEACH Services

❑ Core Training
The core trainings are led by our regional provider teams on-site at PCP's practice or at a nearby location. Core trainings can be provided through a series of 2-3 hour sessions or in one longer program depending on PCP needs. Our regional provider teams cover assessment and management of the important mental health issues that children and adolescents face.

❑ Intensive Trainings
Project TEACH also offers specialized, in-depth programs in each region. These trainings address how to recognize, assess, and manage mild-to-moderate mental health concerns in children and adolescents.

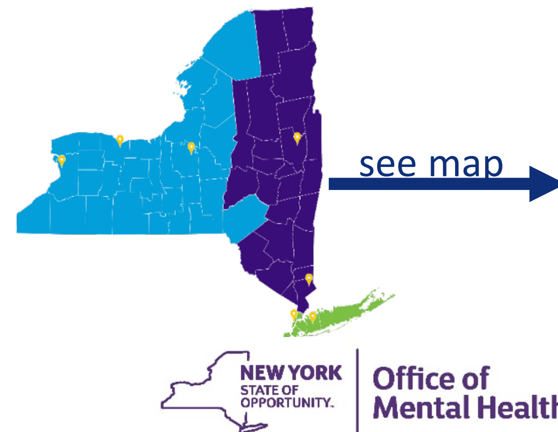
❑ Online Trainings
When possible, we provide access to on-demand content from our live trainings. Beginning in 2018, Project TEACH plans to offer more online training opportunities on a variety of topics.

❑ Face to Face Consultations
PCPs can also request face-to-face consultations with child and adolescent psychiatrists for the children and families in their practice.

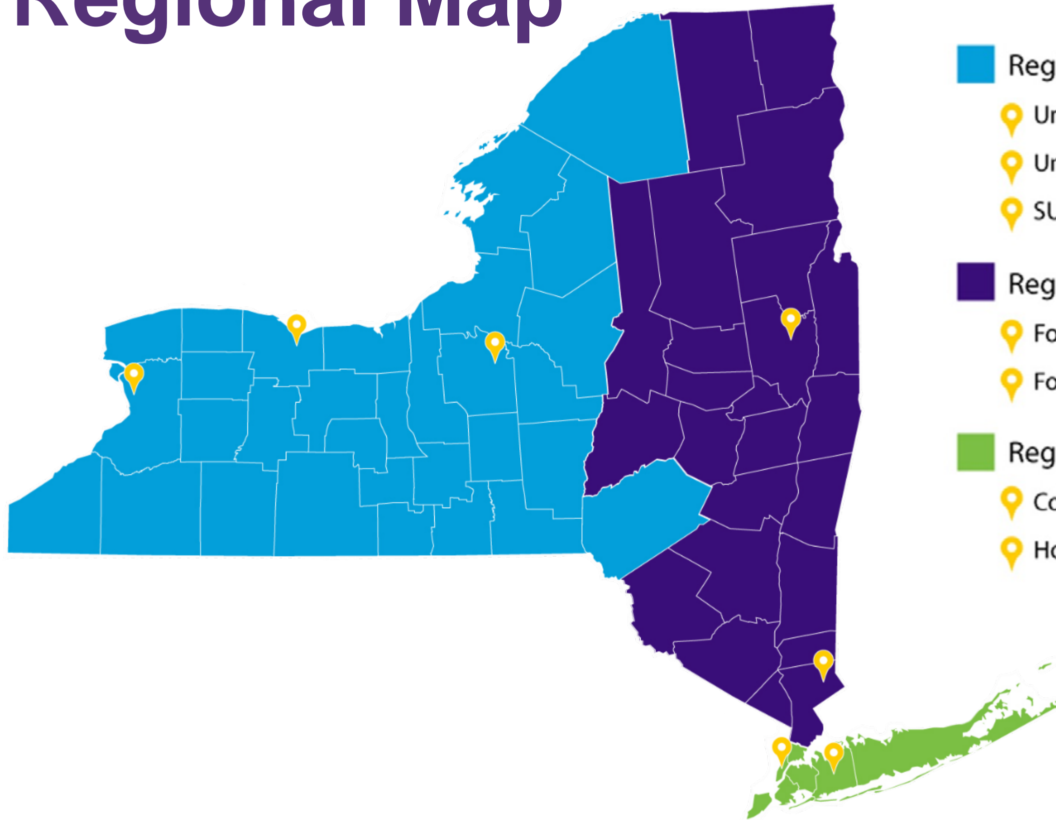
- If a PCP office would like to offer consultations via videoconference, Project TEACH regional provider teams can work with them to make this service available.
- It is our expectation that face-to-face consultations will occur within two weeks of PCP requests. All face-to-face consultations are followed by written reports to the referring prescriber(s).

❑ Telephone Consultations
Project TEACH allows pediatric primary care providers (PCPs) to speak on the phone with child and adolescent psychiatrists. Ask questions, discuss cases, or review treatment options. Whatever they need to support their ability to manage their patients

❑ Referrals & Linkages
Linkage and referral services help pediatric primary care providers and families access community mental health and support services. This includes clinic treatment, care management, or family support. Project TEACH can refer PCPs to appropriate and accessible services that children and families in their practice need



Regional Map



Region 1 - (855) 227-7272
- University at Buffalo Jacobs School of Medicine and Biomedical Sciences
- University of Rochester School of Medicine and Dentistry
- SUNY Upstate Medical University

Region 2 - (844) 892-5070
- Four Winds- Saratoga
- Four Winds- Westchester

Region 3 - (855) 227-7272
- Columbia University Medical Center/New York State Psychiatric Institute
- Hofstra Northwell School of Medicine

Project TEACH Numbers

	Cumulative through 7/30/2017
Physicians Enrolled	2,682
Trainings	136
Face to Face Consultations	1,671
Phone Consultations	11,218
Linkage Calls	3,808

Healthy Steps

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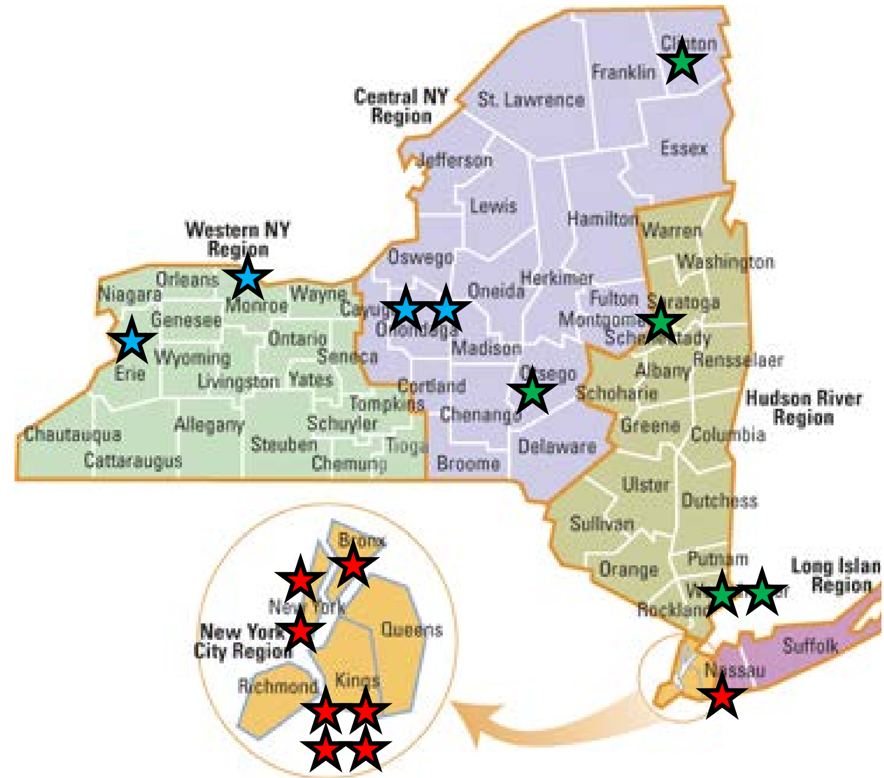
Healthy Steps

- Evidence-based primary care prevention program that assists the pediatrician and other health care providers to expand the primary focus beyond physical health to emphasize social-emotional and behavioral health and support family relationships

- Currently 17 OMH Healthy Steps sites in areas where children are disproportionately at risk for social and emotional concerns:
  - FQHC, Hospital-Based Clinics, Community Health Centers, Private Practices;
  - High need communities with high poverty rates in urban and rural settings;
  - 85% of children receive Medicaid/CHP or are uninsured.



Components of a Healthy Steps Site

- Enhanced well-child screening following a periodic schedule
- Maternal Depression screening and ACE screening
- Parent Education Groups
- Home Visiting as indicated
- Access to support between visits
- Connections to community resources
- Care coordination/systems navigation
- Positive parenting guidance and information

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Enrollment as of June 30, 2017

Quarter ending June 30, 2017
CHILDREN ENROLLED ON CASELOAD 17 SITES

Category	Children enrolled
Pre	26
0-4 months	530
5-11 months	172
12-17 month	43
18-23 months	32
24-29 months	14
30-36 months	6
37-60 months	4
Total children on caseload	827

827 Children were enrolled into Healthy Steps

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Children’s Managed Care

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Children's Managed Care Goals

- Increase access to appropriate interventions
- Enhance service array
- Offer children Medicaid services within a Managed Care delivery system
  - Integrate the delivery of physical and behavioral health services
  - Integrate approaches to care planning and service provision
- Shift focus from volume to achieving quality outcomes

Children’s Medicaid System Transformation

- Transition of six 1915(c) waivers to 1115 Waiver authority
  - Office of Mental Health (OMH) Serious Emotional Disturbance (SED) Waiver
  - Department of Health (DOH) Care at Home (CAH) I/II waiver
  - Office for People with Developmental Disabilities (OPWDD) Care at Home Waiver
  - Office of Children and Families (OCFS) Bridges to Health (B2H) SED, Developmental Disability (DD) and Medically Fragile Waivers
- Alignment of 1915(c) HCBS under one array of Home and Community Based Services (HCBS) authorized under 1115 Waiver
- Remove the Managed Care exemption for children now in six 1915(c) waivers
- Transition to Health Home Care Management
  - Care Management provided under 1915(c) Transition to Health Home Care Management

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Key Components

- Transition of certain carved out Behavioral Health services into Managed Care benefit package
- Six New State Plan Services for Children
- Lifting the exemption of children in foster care with Voluntary Foster Care Agency (VFCA) to Managed Care (January 1, 2019)
- Expansion of Children's aligned HCBS eligibility to Level of Need Population (January 1, 2019)
- All services available to eligible members through both the fee-for-service and Managed Care delivery systems, based on the individual's enrollment

After Transition

- Health Home care management for children with two or more chronic conditions, serious emotional disturbance (SED), complex trauma, HIV (Children Health Home launched in December 2016)
- Current State Plan services PLUS
  - Six new state plan services
- Expanded array of 12 HCBS based on expanded target, risk, and functional criteria with Health Home care management
- Integrate and transition behavioral health benefits to managed care plan
- Transition foster care population to managed care
- Encourage transitional care and continuity of care across children serving systems (education, child welfare, juvenile justice)
- Shift focus to quality, monitoring, and tracking and reward quality outcomes (value based payments)

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Systems of Care

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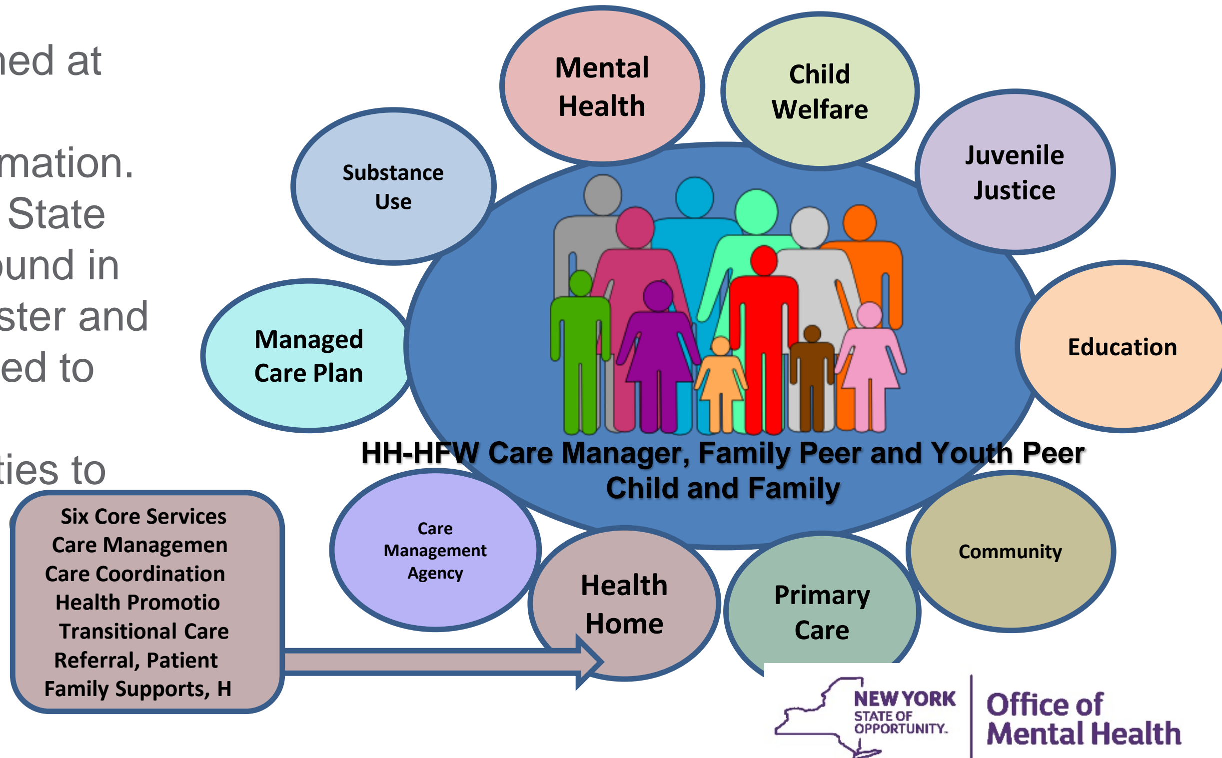
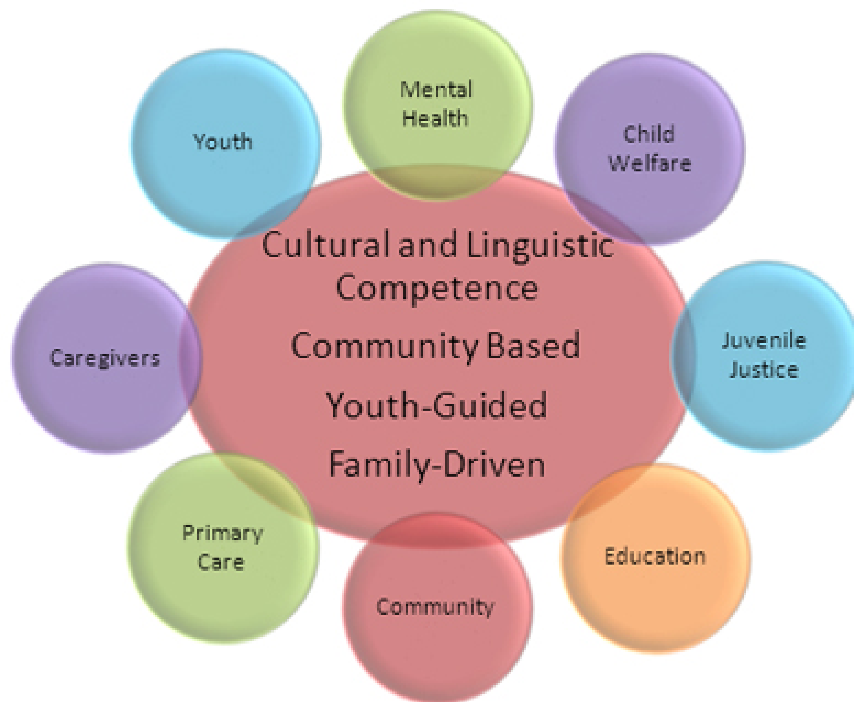
Systems of Care Expansion: Advancing Care through Health Integration and EVidence-based Effort (ACHIEVE)

- ACHIEVE, is a pilot project aimed at promoting SOC values and accountability for local transformation.
- ACHIEVE will pilot a New York State Model of High Fidelity Wraparound in Erie, Rensselaer and Westchester and will use data and lessons learned to replicate statewide
- Working with many other counties to build on their existing Systems of Care efforts



SOC Values

1. Family driven
2. Youth guided
3. Community-based
4. Culturally and linguistically competent
5. Individualized and community based
6. Evidence based and community defined practices



NYS ACHIEVE – Project Partners

YOUTH POWER!

Project Outcomes

- ❑ Formalize a State training model to Support HFW
- ❑ Build County Capacity to Provide HFW
- ❑ Enhance Statewide Workforce Development to Replicate and Sustain HFW

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Changes on the Horizon:

- OMH Strategic Planning to align our vision with resources and drive organizational performance
- Crisis System Design
- Clinical and Regulatory Design Improvements: Telepsychiatry, IOP, Integration
- Suicide Prevention

Christopher Tavella, Ph.D.,
Executive Deputy Commissioner

Strategic Planning & System Redesign

"Where we are going."

"How we are getting there."

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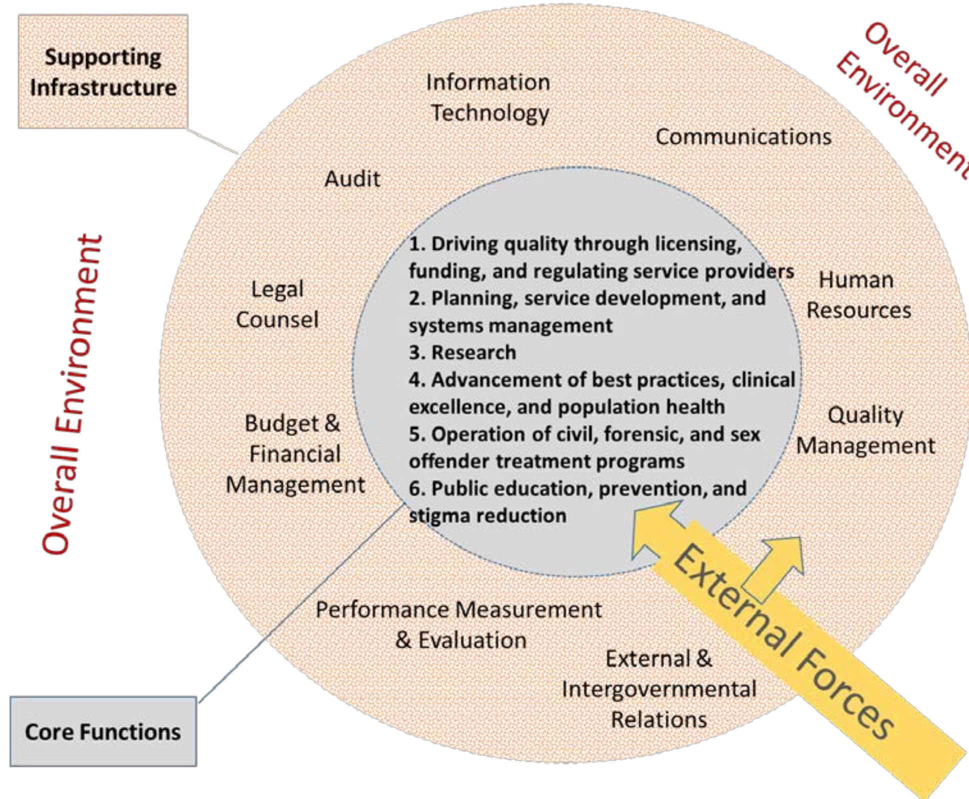
Operations: Core & Supporting



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Crisis System

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Vision for Behavioral Health Crisis Response

- Recovery-oriented, person-centered, and culturally/linguistically competent behavioral health crisis management
- Available to all New Yorkers
  - Includes children, adolescents, and adults
  - Regardless of payment source or ability to pay
- Locally based system that integrates existing crisis infrastructure (state, local and Medicaid funded) with newly available resources in managed care, DSRIP and Value Based Payment
- Build on, not replace local crisis systems
- Interface with criminal justice/law enforcement system

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Key Elements of BH Crisis Response Systems

- 24-hour centralized (county- or regionally-based) telephonic emergency response and triage hotline with capacity to link directly to appropriate ambulatory and emergency services
- Rapid mobile community-based response capability based on the population and geography of the region with the goal of a maximum 3 hour response time
- Short-term and intensive crisis respite services
- Non-hospital crisis stabilization/crisis diversion centers
- Rapid access to appropriate levels of post ED or IP follow up (e.g. IOP, PHP, clinic, etc.)
- Data-sharing and mobile access to individuals' medical history, treatment information, and, if available, crisis response plan
- Integration of peer support services at each level
- Capacity to respond to crises for adults, adolescents, and children
- Coordination with law enforcement

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Reducing Adverse Community Events

- Risk assessment and identification, using IT and clinical tools
- Engagement and wraparound supports, “Pathway Home” model
- Partnering with elements of crisis and first response system beyond MH system; e.g. emergency departments, law enforcement

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Regulatory Reform: Telepsychiatry, Intensive Outpatient Program

Telepsychiatry & Intensive Outpatient Program

- Telepsychiatry: Pursuing further regulatory flexibility to expand eligible hub (physician) sites while ensuring quality
  - Reviewing telemedicine companies that employ psychiatrists
  - Expanding to other licensed MH practitioners, and to PROS; regulations in development
  - 53 sites currently approved for telepsych; 20 additional under review
- Intensive Outpatient Program (IOP)
  - IOP guidance issued in Feb. 2017, 11 approved clinics; 5 additional under review
  - Working on partial hospital program (PHP) regulations to increase flexibility, and allow IOP in PHP settings, target date 2018

Getting to Zero: Suicide Prevention

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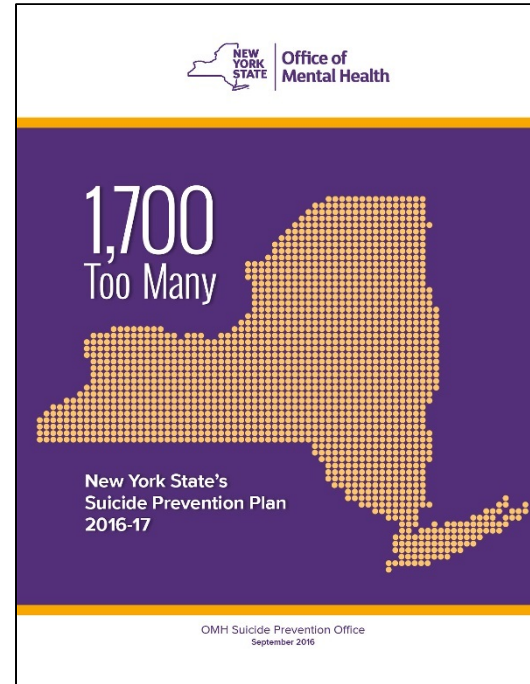
Suicide Prevention

- Continuing to advance the OMH Suicide Prevention Office plan outlined in “1,700 Too Many,” report issued in 2016
- Recent federal grant, and PSYCKES CQI module increasing provider adoption of the Zero Suicide model
- Suicide Prevention Taskforce in formation



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Discussion, Comments and Questions

Community Stakeholders & Panelists

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Thank You!

Questions, comments and remarks accepted through December 15th.

transformation@omh.ny.gov

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